CHAPTER 3 — ENROLLMENT AND APPLICATION

300 Applying for Income Continuation Insurance – New Employee

The Income Continuation Insurance (ICI) program is available to all eligible State employees. On an employee's first day of Wisconsin Retirement System (WRS) covered employment, the employer must provide them with an *Income Continuation Insurance* brochure (ET-2106), which explains the ICI program, along with an *Income Continuation Insurance Application* (ET-2307). The employee **must** complete the employee information area of the application and return it to the employer regardless of whether electing or declining coverage. The employer must complete the relevant employer information on all applications and submit the completed applications to the Department of Employee Trust Funds (ETF). (Refer to the application for address information.)

301 Three Enrollment Opportunities

The ICI program is available to all eligible State employees and provides replacement income during periods of short-term disability as well as those lasting for extended periods. The ICI program has two levels of coverage:

Standard ICI coverage:

- is available to all eligible State employees.
- provides coverage on the employee's annual earnings up to $64,000.
- has a maximum monthly benefit of $4,000.
- provides State contribution toward premium for State employees at specified sick leave balances.
- provides State contribution toward premium for UW faculty after 12 months State service or 130 days sick leave accumulation.

Supplemental ICI coverage:

- requires enrollment in standard ICI.
- permits enrollment annually without providing evidence of insurability.
- provides coverage on the employee's annual earnings up to $120,000.
- has a maximum monthly benefit of $7,500, in conjunction with standard coverage.
- requires the employee to pay the entire premium.

Note: Earnings for the determination of premium amounts is defined as the basic salary, including permanent add-on pay awarded to employees holding certain educational degrees, certifications, licenses or credentials but does not include overtime pay, temporary additional pay such as night differential, weekend differential and income from any other sources. For employees working less than 12 calendar months, such as seasonal, academic, project or limited term employees, the monthly premium is based on the total earnings paid to the employee in the previous calendar year as reported to the WRS, or a projection of earnings if there were no previous years earnings.

There are three opportunities for an eligible State employee to enroll in the ICI program:

1. Initial Enrollment Period

An eligible State employee as defined in chapter 2, may enroll in standard and supplemental ICI without evidence of insurability by submitting a completed *Income Continuation Insurance Application* (ET-2307) to the employing State agency within 30 days of the employee's initial eligibility date. An employee who becomes initially eligible while on military leave must submit an application within 30 days of return to work.

Employees with earnings of $64,000 or less are limited to standard ICI. Enrollment in supplemental ICI is optional and may occur during the employee's initial enrollment period or on an annual basis, concurrent with the annual deferred enrollment period. Supplemental ICI enrollment requires enrollment in standard ICI.

An eligible employee of more than one employer, or one who falls under different ICI plans with different elimination periods, must file a separate application for each position held. (Refer to chart in subchapter 202.)

2. Deferred Coverage

State Employees – The requirement to submit evidence of insurability is waived for State employees who decline to enroll during their initial enrollment period, but who

subsequently become eligible for State share, or an increase in State share, toward the premium by accumulating specified levels of sick leave for the first time. State contribution toward the premium is only available when accumulated sick leave falls within premium categories 3, 4, 5 and 6. (Refer to Chapter 4 for information on premium categories.)

Upon first reaching one of the specified sick leave premium categories, the employee is eligible to enroll in ICI through the deferred coverage provision. The employee's sick leave accumulation at the end of the last complete payroll period in any calendar year must be such that it is the first time their sick leave falls within that premium category. The only exception to this is that a State employee whose accumulated sick leave exceeds 1040 hours at the end of **any** calendar year qualifies for deferred enrollment. An employee who becomes eligible for deferred coverage must complete an *Income Continuation Insurance Application*. The application must be received, signed and dated by the State agency on or before January 30, with coverage effective April 1.

- Supplemental ICI – Employees with annual earnings exceeding $64,000 wishing to enroll in supplemental ICI may do so annually without submitting evidence of insurability. Supplemental ICI enrollment requires previous or concurrent enrollment in standard ICI. Employees without standard ICI coverage and who are not eligible to apply for standard coverage through the deferred enrollment provision, cannot enroll for supplemental coverage. An employee who wishes to add supplemental coverage must complete an *Income Continuation Insurance Application*. The application must be received, signed and dated by the State agency on or before January 30, with coverage effective April 1.

- Premium Category 3 – Deferred enrollment in premium category 3 is available when a full-time employee initially accumulates 80 hours of sick leave as of the end of the last complete payroll period in the preceding calendar year. (Refer to subchapter 400B for more details.)

UW Faculty/Academic – The requirement to submit evidence of insurability is waived for UW faculty who declined to enroll during their initial enrollment period, but who subsequently become eligible for State share toward the premium, or whose accumulated sick leave exceeds 1040 hours at the end of **any** calendar year.

The State premium contribution for UW faculty is effective following completion of one year of State WRS creditable service. Once the faculty employee meets the one year of State WRS service requirement, they are eligible to enroll in the ICI program through the deferred coverage provision. UW faculty enrolling for ICI coverage must select an elimination period of 30, 90, 125, or 180 calendar days.

For UW faculty applying upon eligibility for State share of premium, an *Income Continuation Insurance Application* must be completed and received by the UW payroll/personnel office within 30 days from the date the faculty employee completed the one year State WRS service requirement. Coverage is effective the first of the month on or after the employer's receipt date.

Example: A UW faculty employee hired September 1 must submit an application within 30 days after August 31 of the following year.

It is recommended, if applying through the one year State service deferred coverage provision, that UW faculty complete the *Income Continuation Insurance Application* at the onset of UW employment and indicate on the application that they desire that coverage be effective when the State contributes toward the premium.

For UW faculty applying upon accumulation of 1040 hours of sick leave, a completed *Income Continuation Insurance Application* must be received, signed and dated by the UW on or before January 30, with coverage becoming effective April 1.

- Supplemental ICI – Employees with annual earnings exceeding $64,000 wishing to enroll in supplemental ICI may do so annually without submitting evidence of insurability. Supplemental ICI enrollment requires previous or concurrent enrollment in standard ICI. Employees without standard ICI coverage and who are not eligible to apply for standard coverage through the deferred enrollment provision, cannot enroll for supplemental coverage. An employee who wishes to add supplemental coverage must complete an *Income Continuation Insurance Application*. The application must be received, signed and dated by the State agency on or before January 30, with coverage effective April 1.

3. Evidence of Insurability

The *Evidence of Insurability Application* (ET-2308) is required for State employees wishing to enroll in the standard and supplemental ICI program who missed the initial enrollment period and any deferred enrollment opportunity. The *Evidence of Insurability Application* is also required for insured UW faculty wishing to select a shorter elimination period. Application for supplemental ICI through evidence of insurability is only possible in conjunction with standard ICI.

An eligible employee who fails to apply for standard ICI within 30 days of becoming eligible may apply for coverage by providing evidence of insurability. Eligible employees (actively employed and not on leave of absence or layoff) may apply at any time prior to age 70 by completing an *Evidence of Insurability Application* and forwarding it directly to ETF. An application received by ETF more than 30 days after its completion date (i.e., the date the application is signed) will be rejected and the employee will be required to complete a new application.

The *Evidence of Insurability Application* requires that the employee submit medical proof of insurability. The plan's third party administrator will review the application.

> **Note:** Any costs incurred for exams, tests or procedures conducted to prove eligibility are the responsibility of the employee.

Employers receive notice from the third party administrator of the approval or denial of the *Evidence of Insurability Application*, which should be retained for their records. (Refer to subchapter 309-312 for sample notices.)

Employees have the right to submit a written request to the third party administrator for reconsideration if the *Evidence of Insurability Application* is denied. The third party administrator must receive the written request within 90 days of the denial. Should the reconsideration also result in denial, the employee has the right to request that ETF do a subsequent review of the denial and render a Departmental Determination. The ETF reconsideration request must be made within 90 days of

the third party administrator's reconsideration denial. In the event the Departmental Determination upholds the denial, the employee may not file a new application until a period of one calendar year elapses from the date of the initial application denial.

(Refer to subchapter 307 for instructions on completing the *Evidence of Insurability Application*.)

302 Employee Completion of the *ICI Application* (ET-2307)

The employee **must** complete the following items on the *Income Continuation Insurance Application* and return the application to the employer no later than 30 days following the initial eligibility date. (Refer to the sample form in subchapter 304.)

a. Complete legal name.
b. Entire permanent address.
c. Social Security number.
d. Birthdate (employee must be under age 70).
e. Sex.

Employee Section 1 – Standard ICI Coverage

f. Check the box indicating the election of standard ICI coverage, the choice not to elect coverage, or the desire to cancel coverage.

Employees electing standard ICI coverage whose annual earnings exceed $64,000 should proceed to section 2. Employees with earnings of $64,000 or less should proceed to section 3.

Employees not electing standard ICI coverage or canceling coverage should proceed to section 4. (Note: Canceling standard ICI coverage automatically cancels any existing supplemental coverage.)

Employee Section 2 – Supplemental ICI Coverage

g. Available to employees whose annual earnings exceed $64,000 and who are enrolled in, or initially applying for, standard ICI coverage.

Check the appropriate box indicating the election of, the choice not to elect, or the desire to cancel supplemental ICI coverage. (Note: Checking the box indicating a cancellation of supplemental coverage is appropriate for those employees wishing to cancel supplemental ICI coverage but maintain standard ICI coverage for their earnings up to $64,000.)

Employees electing supplemental ICI coverage as part of their initial enrollment in ICI coverage should proceed to section 3. Employees electing supplemental ICI coverage who already have standard ICI coverage should proceed to section 4.

Employees not electing supplemental ICI coverage or canceling coverage should proceed to section 4.

Employee Section 3 – Questions applicable to employment status

h. *State Employees and UW Faculty/Academic Staff*:

Indicate the most recent previous State agency at which the applicant was employed, if any, and the dates of employment. If none, indicate NA.

i. *UW Faculty/Academic Staff **only***:

Select an elimination period and indicate when coverage should become effective (i.e., as soon as possible, or when State contributes toward premium).

Note to UW Faculty/Academic Staff—Select an elimination period when:

- ❑ Applying for standard ICI and, if eligible, supplemental ICI coverage.
- ❑ Applying for a longer elimination period than previously selected. (Evidence of Insurability is required to change to a shorter elimination period.)

UW Faculty/Academic Staff members currently enrolled in ICI who are electing supplemental ICI coverage should not complete this section unless they wish to lengthen their elimination period; in these cases the employer must check the appropriate box in the "Employer Section" or the application will be returned.

Employee Section 4 – Employee Signature

j. Employee signature. (If missing, the application is invalid and will be returned for signature.)
k. Employee's daytime telephone number.
l. Date of signature.
m. Employee returns application to employer.

303 Employer Completion of the *ICI Application* (ET-2307)

The employer **must** complete the following items on the *Income Continuation Application* and forward the application to ETF. (Refer to the sample form in subchapter 304.)

a. Indicate the reason for submitting the application by checking the appropriate box and indicating the occurrence date.

- ❑ **Immediately Eligible On.** Check this box for employees who previously completed six months of service under the WRS. Indicate the occurrence date.

- ❑ **New employee will have participated in WRS for six calendar months on**. Check this box for new employees and rehired employees who have not previously completed six calendar months of service under the WRS and indicate the occurrence date.

- ❑ **Reinstating coverage upon return from layoff or leave of absence.**

- ❑ **Date temporary layoff/LOA began:** _____

- ❑ **Date employee returned** ____ . Check this box if an employee who previously had ICI coverage takes a leave of absence, allows coverage to lapse and then returns to eligible employment. Insert the date the leave began and the date the employee returned from leave. Indicate the occurrence date.

- ❑ **Transferred from another State agency on.** Check this box for employees transferring from another State agency and indicate the transfer date.

- ❑ ***(UW Faculty/Academic Staff only)*** **Changed to a longer elimination period effective on:** Check this box if the employee wants to elect a longer elimination period. An employee may change to a longer elimination period at any time. However, if an employee wants to change to a shorter elimination period, the employee must apply through evidence of insurability.

- ❑ **Eligible through deferred coverage *(State employees and UW Faculty/Academic Staff)* on.** Check this box for employees eligible through deferred coverage and indicate the coverage begin date.

- ❑ **Other.** Check this box for a situation that does not fit one of the other categories listed above and list the effective date of coverage. For example:
    - Return from leave of absence.
    - Applying for supplemental ICI coverage during annual deferred enrollment.
    - Canceling supplemental ICI coverage only.
    - Reinstatement due to grievance/arbitration.
    - Return from military leave.

b. Previous Service – Indicate if the employee participated under WRS prior to being hired by you, whether you have completed a previous service check and the source of the check, and the date WRS participation began with you. **A previous service check must be completed for all employees.**

c. Earnings – Use the employee's WRS earnings as reported in the preceding calendar year or, if applicable, the employee's projected calendar year earnings and indicate whether the earnings are monthly or biweekly.

d. Basis of Employment – Check whether the employee's basis of employment is full-time, part-time, limited term, seasonal, project, or academic year. If part-time, indicate the percentage of full-time employment.

e. ICI Monthly Premium – Indicate the appropriate employee and employer premium share. (Refer to subchapters 401 and 402.)

f. Supplemental ICI Monthly Premium – Indicate the premium; refer to the supplemental premium rate sheet. (The employee pays the entire premium for supplemental ICI coverage.) (Refer to subchapters 401 and 402.)

g. Sick Leave Information for Deferred Coverage or Reinstated or Rehired Employees – Indicate the total accumulation of sick leave credits for the previous 2 calendar years.

h. Employer name – Use the same name used for Social Security reporting.

i. Employer Number 69-036 – The Employer Identification Number (EIN) is a 12-digit number beginning with 69-036. Indicate the last seven digits of this number (XXXX-XXX).

j. Date Received by Employer (MM/DD/CCYY) – The date the employer received the employee's completed application. This date determines when the insurance becomes effective. If this date is missing the coverage effective date will be based on the date ETF receives the application and could cause delay or denial of coverage.

k. Employer Agent Signature – The WRS agent or designated representative must certify that the information on the application is true and correct.

l. Prepared By – Indicate the name of the person preparing the form.

m. Daytime Telephone Number – The telephone number of the employer contact person/preparer.

n. Effective Date (MM/DD/CCYY) – Indicate the coverage effective date – the first of the month on or following receipt of application by the employer. For example, coverage is effective on the:

- eligibility date for applications received on or prior to the eligibility date.
- 1st on the month for applications received on the 1st of the month.
- 1st of the following month for applications received on the 2nd through the 31st of the month.

304 Sample - *Income Continuation Insurance Application* (ET-2307)

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

State Employee
Wis. Stat. § 40.61

INCOME CONTINUATION INSURANCE APPLICATION

I. EMPLOYEE: COMPLETE PART I *TYPE OR PRINT IN INK, SIGN, AND RETURN TO EMPLOYER*

Name / Address					
Last	First	Middle I.	Maiden/Former	Social Security Number	
Street No.	Street Name			Birthdate *(MM/DD/CCYY)*	
City	State	Zip	Country and Mail Code (if not USA)	Sex ☐ Male ☐ Female	

Complete sections 1 – 3 (2 and 3 if applicable) and sign at section 4.

1. INCOME CONTINUATION INSURANCE (ICI) COVERAGE
Check One:

☐ I elect ICI coverage and authorize payroll deductions for premiums. *If your annual earnings exceed $64,000.00, go to #2. If not, proceed to #3.*

☐ I do not elect ICI coverage. *Sign below at #4.*

☐ I wish to cancel my ICI coverage. (Checking this box also cancels Supplemental ICI coverage, if in effect.) *Sign below at #4.*

2. SUPPLEMENTAL ICI COVERAGE: Only available to employees whose annual earnings exceed $64,000.00 and who are currently enrolled in, or are applying for, ICI coverage. *Check One:*

☐ I elect Supplemental ICI coverage. I understand that Supplemental ICI premiums are paid by the employee with no employer contribution. I authorize payroll deductions for Supplemental ICI premiums. (UW Faculty/Academic Staff: If already enrolled in ICI coverage, I understand that the elimination period previously selected will be applied to Supplemental ICI coverage.) *If you elected ICI coverage in #1, go to #3. If you already have ICI coverage, sign below at #4.*

☐ I do not elect Supplemental ICI coverage. *If you elected ICI coverage in #1, go to #3. If not, sign below at #4.*

☐ I wish to cancel my Supplemental ICI coverage only. *Sign below at #4.*

3. Answer only those questions applicable to your employment status (once completed, sign below at #4.):

STATE EMPLOYEES AND UW FACULTY/ACADEMIC STAFF: ☐ I was most recently employed by the following State agency: _____ From *(MM/DD/CCYY)* _____ To *(MM/DD/CCYY)* _____

UW FACULTY/ACADEMIC STAFF ONLY:
I elect the following calendar day elimination period for ICI coverage (and Supplemental ICI coverage, if applicable): ☐ 30-day ☐ 90-day ☐ 125-day ☐ 180-day

I want my coverage to be effective: ☐ As soon as possible *(upon completion of 6 mos. WRS service)* _____ ☐ When State contributes toward premium *(defer coverage for 12 months)* _____

4. I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I authorize the monthly employee share premium deduction (indicated below) from my earnings to provide ICI and Supplemental ICI coverage (if selected). I understand that if premiums are not deducted, I do not have ICI coverage.

Sign and Return to Employer

Signature of Employee	Daytime Telephone	Date *(MM/DD/CCYY)*

II. EMPLOYER: COMPLETE PART II

Reason to submit *application (Check appropriate box and indicate occurrence date)*

☐ Immediately eligible on:

☐ New employee will have participated in WRS for six calendar months on:

☐ Reinstating coverage upon return from temporary layoff or leave of absence. Date temp layoff/LOA began: _____ Date employee returned: _____

☐ Transferred from another State agency on:

☐ *(UW Faculty/Academic Staff only)* Changed to a longer elimination period effective on: (Evidence of Insurability is required to change to a shorter elimination period.)

☐ Eligible through deferred coverage (*State employees and UW Faculty/Academic Staff*) on:

☐ Other (*specify*):

Previous Service - Complete Information

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check, completed ☐ Yes ☐ No
Source of previous service ☐ Extranet ☐ ETF
3. Date WRS participation began with the current employer *(MM/DD/CCYY)*

Earnings	Basis of Employment	ICI Monthly Premium		Supplemental ICI Monthly Premium
$ ☐ Monthly ☐ Biweekly	☐ Full-Time ☐ Seasonal ☐ Project ☐ Part-Time _____ % ☐ Academic Year ☐ LTE	Employee Share $	Employer Share $	Employee Share $

SICK LEAVE INFORMATION FOR DEFERRED COVERAGE OR REINSTATED OR REHIRED EMPLOYEES
Total accumulation of sick leave credits for the preceding 2 calendar years:

Year	Beginning Balance	Sick Leave Earned	Sick Leave Used	Ending Balance

Employer Name		Employer Identification Number (EIN) 69-036	Date Received by Employer *(MM/DD/CCYY)*
Employer Agent Signature	Prepared By	Daytime Telephone ( )	Effective Date *(MM/DD/CCYY)*

ET-2307 (REV 02/2005) *Return all copies of this application to your payroll section.*

305 Distribution of Copies

Following completion of the *Income Continuation Application* (ET-2307), distribute the individual application copies as follows:

1. Forward the top copy of the application to ETF, regardless of whether the employee declines, cancels or elects coverage. Each application will be audited and problem applications will be reviewed with the employer.
2. Retain the Employer Copy for verification purposes.
3. Give the Employee Copy to the employee.

306 Application Due Date and Effective Date of Coverage (Chart)

The salary basis upon which ICI premium rates are determined vary as follows;

- 12-Month Employee – Basic salary, including permanent add-on pay awarded to an employee who holds certain educational degrees, certifications, licenses or credentials, in effect at the time the employee becomes insured. Temporary additional pay and overtime is not included.

- Less than12-Month Employee with Previous Year's Earnings – Project, LTE, seasonal or academic year employees who are employed for less than 12 calendar months have a salary basis using the previous calendar year earnings rounded to the next highest thousand divided by 12. If these employees did not receive earnings for the entire previous calendar year or resumed employment after an interruption of service extending 3 consecutive months or more, the earnings are estimated for the 12 months.

- Less than12-Month Employee without Previous Year's Earnings – Use projected 12 month earnings.

The following table provides guidelines for determining *Income Continuation Application* (ET-2307) due dates and ICI coverage effective dates for specific employment situations. (Refer to subchapters 201 and 204 for information on ICI eligibility dates.)

	EMPLOYMENT SITUATION	APPLICATION TYPE	APPLICATION DUE DATE	COVERAGE EFFECTIVE DATE
NEW	New State employee – no previous service.	*ICI Application* (ET-2307)	No later than 30 days following completion of 6 months WRS service.	Eligibility date or 1st of month on or after employer's receipt of completed application, whichever is later.
REHIRES	Rehired, previously insured employee following 30 day break in employment with no WRS benefit taken.	*ICI Application* (ET-2307)	No later than 30 days from rehire.	1st of month on or after employer's receipt of completed application.
	Rehired WRS annuitant electing WRS coverage by submitting completed ET-2319.	*ICI Application* (ET-2307)	No later than 30 days from WRS begin date at current employer.	WRS begin date at current employer or 1st of month on or after employer's receipt of completed application, whichever is later.

	EMPLOYMENT SITUATION	APPLICATION TYPE	APPLICATION DUE DATE	COVERAGE EFFECTIVE DATE
LEAVES	Previously insured employee returning from military leave during which coverage lapsed.	*ICI Application* (ET-2307)	Within 30 days of return to work from military leave.	1st of month on or after employer's receipt of completed application.
	Previously insured employee returning from LOA during which coverage lapsed.	*ICI Application* (ET-2307)	Within 30 days of return to work from LOA.	1st of the month on or after employer's receipt of completed application.
	Previously uninsured employee returning from LOA.	*Evidence of Insurability* (ET-2308)	Any time but not within one year of a previous *Evidence of Insurability* application's denial.	1st of month following approval of *Evidence of Insurability* application.
TRANSFERS	Insured State employee transferring to another State agency within 30 days*.	*ICI Application* (ET-2307)	Within 30 days of transfer.	1st of month on or after employer's receipt of completed application. Coordinate premium payment with prior agency to ensure continuous coverage.
	Insured UW Faculty transferring to State (non-Faculty) employment*.	*ICI Application* (ET-2307)	Within 30 days of transfer.	1st of month on or after employer's receipt of completed application. Coordinate premium payment with prior agency to ensure continuous coverage.
	Insured State employee transferring to UW Faculty*.	*ICI Application* (ET-2307)	Within 30 days of transfer.	1st of month on or after employer's receipt of completed application. Coordinate premium payment with prior agency to ensure continuous coverage.
UW FACULTY	New UW Faculty – no previous service – no employer contribution.	*ICI Application* (ET-2307)	1st of month on or after completion of 6 months WRS service.	Eligibility date or 1st of month on or after employer's receipt of completed application, whichever is later.
	New UW Faculty completes one year State service – eligible for employer contribution.	*ICI Application* (ET-2307)	No later than 30 days following completion of one year State service.	1st of month on or after employer's receipt of completed application.
	Deferred Coverage – UW Faculty accumulates 1040 hours of sick leave.	*ICI Application* (ET-2307)	On or before January 30.	April 1.
MISCELLANEOUS	Previously insured employee reinstated due to arbitration.	*ICI Application* (ET-2307)	Within 30 days of reinstatement.	1st of the month on or after employer's receipt of completed application.
	Deferred Coverage – State (non-Faculty) employee reaches premium plateau 3 – 5 for first time, or has accumulated 1040 hours sick leave.	*ICI Application* (ET-2307)	On or before January 30.	April 1.
	Eligible employee who missed other enrollment opportunities.	*Evidence of Insurability* (ET-2308)	Any time but not within one year of a previous *Evidence of Insurability* application's denial.	1st of month following approval of *Evidence of Insurability* application.
	Currently insured, eligible employee electing Supplemental coverage.	*ICI Application* (ET-2307)	On or before January 30.	April 1.

* If there is a break in service of 30 or more days when transferring positions, the employee is treated as a new employee.

307 Instructions for Completing the *Evidence of Insurability Application* (ET-2308)

The *Evidence of Insurability Application* provides additional opportunities for employees under age 70 to enroll in the ICI program if coverage was previously declined, cancelled, lapsed or denied. It also provides a method by which employees may enroll after missing their initial enrollment period or elect a shorter elimination period. The employee must furnish acceptable medical evidence before approval.

The *Evidence of Insurability Application* can be used to apply for supplemental ICI, if eligible, only when also applying for standard ICI. Application through evidence of insurability for supplemental coverage only is not permissible.

Note: Eligible applicants with standard ICI coverage may apply for supplemental ICI coverage annually under the deferred coverage provision. (Refer to subchapter 301.)

A. Employer Responsibilities

1. Review the eligibility criteria outlined in subchapter 200 to determine if the employee is eligible to apply for ICI coverage.

2. Provide the eligible employee with a copy of the *Income Continuation Insurance* brochure (ET-2106) explaining the ICI program.

3. On the *Evidence of Insurability Application*—complete the employee's Social Security number, current employing State agency, employer number 69-036-(XXXX-XXX), occupation and the date eligible for WRS. Give the application to the employee to complete.

4. Instruct the employee to read the instructions on the first page of the *Evidence of Insurability Application*. Incomplete applications will be returned to the employee and will delay application processing.

B. Employee Responsibilities

1. Read the instruction page of the *Evidence of Insurability Application* and follow the directions. Complete the form in its entirety, including all pertinent information, then sign and date the form. Unanswered questions, incomplete answers to questions, lack of signature and/or date will result in the application being returned.

2. Submit the application to ETF no later than 30 days after the date of completion to ensure current medical information. Applications received more than 30 days after the employee signs and dates the application will be rejected. The employee will then be required to complete and submit a new *Evidence of Insurability Application*.

C. Approval/Denial

1. The third party administrator will notify both employee and employer of the approval/denial and the effective date of coverage, if applicable,

approximately 60 to 90 days from ETF's receipt of the *Evidence of Insurability Application*.

2. For approved applications, the effective date of coverage will be the first of the month following the date the evidence is approved. Premiums are due from that day forward.

3. For denied applications:

   a. Retain the employer's copy of the denial form for future reference. Additional action by the employer is not necessary.

   b. The employee has the right to request reconsideration of the initial denial by submitting a written request to the third party administrator within 90 days of the date of the initial denial.

   c. The employee has the right to request a subsequent review of the reconsideration's denial by requesting a Departmental Determination within 90 days of that denial.

   b. A new application will not be considered until one-year elapses from the date of denial.

308 Sample – *Evidence of Insurability Application* (ET-2308)

DEPARTMENT OF EMPLOYEE TRUST FUNDS
P.O. BOX 7931
Madison, WI 53707-7931

Clearly print or type your Name and address below:

EVIDENCE OF INSURABILITY APPLICATION
(Income Continuation Insurance)
Wis. Stat. § 40.61

To keep your application confidential, enclose it in a sealed envelope and submit directly to the Department of Employee Trust Funds.

First MI Last

Social Security Number

Birthdate (MM/DD/CCYY)

Sex ☐ M ☐ F | Height ft. in. | Weight lbs.

- Have you ever applied through ICI Evidence of Insurability before? ☐ Yes ☐ No
- Are you applying to shorten your waiting period? ☐ Yes ☐ No
- In addition to ICI, are you applying for supplemental coverage? ☐ Yes ☐ No
  (annual earnings must exceed $64,000 to be eligible for supplemental)

Current Employer or Department

Employer Number
69-036

UW FACULTY AND ACADEMIC STAFF
I elect the following waiting period (calendar days):
☐ 30 day ☐ 125 day
☐ 90 day ☐ 180 day

LOCAL GOVERNMENT EMPLOYEES ONLY
I elect the following waiting period (calendar days):
☐ 30 day ☐ 90 day ☐ 180 day
☐ 60 day ☐ 120 day

Occupation

Date Eligible for WRS (MM/DD/CCYY)

ANSWER EACH OF THE FOLLOWING QUESTIONS CAREFULLY AND COMPLETELY

	YES	NO
1. Are you presently in good health and free from physical impairment and pregnancy? If no, explain.	☐	☐
2. Has any life, health, or accident and sickness insurance application including Income Continuation Insurance been cancelled, rejected, or assigned to a special rate category because of your medical condition? If yes, explain.	☐	☐
3. Have you, within the last 5 years, made claim for or received disability or retirement payments because of an illness or injury? If yes, give date, amount, company, type of illness or injury, type of insurance, and reason.	☐	☐
4. During the last 5 years have you been hospitalized, had surgery, or been advised to have surgery? If yes, give date, hospital, doctor and diagnosis.	☐	☐
5. Have you, within the last 5 years, missed work for more than two weeks because of an illness or injury? If yes, list dates of time off and type of illness or injury.	☐	☐

6. Have you ever been diagnosed or received treatment by a health care provider or had reason to suspect you have had any of the following:

- ☐ Heart Disease/Attack
- ☐ Chest Pain, Angina, or Shortness of Breath
- ☐ Disorder of Heart Muscles, its Nerves or Vessels
- ☐ Irregular Heart Beat, Murmur or Rheumatic Fever
- ☐ Abnormal Blood Pressure
- ☐ Disorder of Veins or Arteries
- ☐ Diabetes, High or Low Blood Sugar
- ☐ Disorder of Kidneys or Bladder
- ☐ Venereal Disease, Syphilis, Gonorrhea, Genital Warts or Genital Herpes
- ☐ Protein, Blood or Sugar in Urine
- ☐ Night Sweats, Persistent Swollen Glands, or Diarrhea
- ☐ Arthritis, Bursitis or Gout
- ☐ Disorder of Back, Neck or Spine
- ☐ Disorder of Muscles, Bones or Joints
- ☐ Temperomandibular Joint Syndrome (TMJ)
- ☐ Recurrent Abdominal Pain or Hernia
- ☐ Stroke, Epilepsy or Seizure Disorder
- ☐ Migraine or Persistent Headaches
- ☐ Mental or Nervous Disorder
- ☐ Dizziness or Paralysis
- ☐ Asthma, Emphysema, Breathing or Lung Disorder
- ☐ Indigestion, Ulcers or Colitis
- ☐ Cancer of any Type, Past or Present
- ☐ Tumor or Cysts
- ☐ Conditions of the Brain or Nervous System
- ☐ Conditions of the Eyes, Ears, Nose or Throat
- ☐ Conditions of the Skin or Lymph Nodes
- ☐ Conditions of the Prostate, Ovaries or Uterus
- ☐ Conditions of the Stomach, Intestines, Gallbladder or Liver
- ☐ Conditions of the Thyroid or any Gland
- ☐ Treatment to limit use of Alcohol, Other Chemicals or Drugs
- ☐ AIDS or any Disorder of Immune System*
- ☐ Human Immunodeficiency Virus (HIV)*
- ☐ AIDS Related Complex (ARC)*

*You are not required to submit, nor are we seeking a result of an HIV Antibody Test.

7. If any of the above are checked, give date, nature and period of disability, doctor's name and address and result.

8. Physician who is most familiar with your medial history. Please include physician's full name, address, city, state, zip code.
   Name: Address:
   Date last visited: Reason for visit:
   Other Physician(s) consulted within the last 5 years: (Add additional names and addresses on a separate sheet of paper, if necessary.)
   Name: Address:

Upon approval of this application I hereby authorize payroll deductions from my earnings. I hereby authorize any and all physicians, hospitals, clinics, etc. to release to the Wisconsin Department of Employee Trust Funds or the ICI Program Administrator information from my health record. I understand that the specific type of information to be released includes any and **all medical and/or treatment records, and may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testings and results, and/or treatment records.** This release is being made for the purpose of applying for insurance. A copy of this authorization shall be considered as effective and valid as the original and is effective for 90 days from the date signed below.

I understand that Wis. Stat. § 943.395, provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true, correct and complete.

Date (MM/DD/CCYY)	Signature	Telephone No.: Work: ( ) Home: ( )

☐ _____ did not respond to several requests for additional medical information
☐ The medical information received from _____
indicates _____ Reapply: _____
Application: ☐ APPROVED ☐ DENIED Date: By:

For ETF only. Effective date of Coverage (MM/DD/CCYY)

ET-2308 (REV 04/2005)

309 Sample – Notice of Approval of Coverage Under Evidence of Insurability

[Date]

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1» «CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI) Disability Benefits
Evidence of Insurability (EOI)
Social Security # XX

Dear Mr. or Ms. «ClaimantsLastName»:

Thank you for completing the Evidence of Insurability Application for enrollment into the Income Continuation Insurance benefit plan.

We have reviewed your Evidence of Insurability application. **We are pleased to inform you that the information provided allows us to approve your enrollment into the Income Continuation Benefit Plan.** Your application has now been approved effective [DATE]. By copy of this letter, your employer is directed to begin payroll deductions for both the standard and supplemental income continuation insurance premiums and to notify you when these deductions begin. The waiting period you selected is XX days**.**

Please be aware that omissions or mistakes in your application could cause a future valid claim to be denied. We urge you to carefully review the answers on your application for accuracy. Please verify that the information is complete, accurate, and any requested medical history has been included. If you find an error, you must write to this office within ten (10) calendar days, along with a copy of your amended Evidence of Insurability application.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: [Employer]
Department of Employee Trust Funds

310 Sample – Notice of Denial of Coverage Under Evidence of Insurability

[Date] **Certified Mail #**

[Employee's Name]
[Address 1]
[City, WI and Zip]

Re: Income Continuation Insurance (ICI)
Evidence of Insurability Application
Social Security #

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Thank you for your application for Income Continuation Insurance coverage through the State of Wisconsin. We have completed our underwriting review of your application for coverage, and have found it necessary to decline coverage for the following reason:

[Reason]

The information used to reach this decision was taken from:

5. EVIDENCE OF INSURABILITY APPLICATION

The reason for this action was based solely on medical underwriting consideration in accordance with standard insurance industry underwriting guidelines.

If you feel that additional information provided by your physician may reverse this determination, you may submit this information directly, along with a written request that authorizes us to reconsider the original decision. Your request should detail the specific reason(s) you feel the decision should be reversed. Please submit this request to:

Broadspire
200 Wheeler Road, 5th Floor
Burlington, MA 01803

Your written request must be received by our office within 90 days from the date of this denial. You will be informed of Broadspire's decision as soon as possible.

If you do not have any additional medical information for consideration, which might reverse our decision, you can reapply for coverage 12 months after the date of this denial.

Once again, thank you for your application and we regret not being able to meet your insurance needs at this time.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: Department of Employee Trust Funds (ETF)

(902)

311 Sample – Notice of Approval of Coverage After Reconsideration

[Date] **Certified Mail # Receipt Number**

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1» «CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI) Disability Benefits
Evidence of Insurability (EOI)
Social Security # XX

Dear Mr. or Ms. «ClaimantsLastName»:

This letter is in response to your request for reconsideration of your Income Continuation Insurance (ICI) application.

We have now completed the review of the additional information supporting your ICI application. **We are pleased to inform you that the information provided warrants the reversal of the original application denial.** Your application has now been approved effective [DATE]. By copy of this letter, your employer is directed to begin payroll deductions for both the standard and supplemental income continuation insurance premiums and to notify you when these deductions begin.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: [Employer]
Department of Employee Trust Funds

312 Sample – Notice of Denial of Coverage After Reconsideration

[Date] **Certified Mail # Receipt Number**

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1» «CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI) Disability Benefits
Evidence of Insurability (EOI)
Social Security # XX

Dear Mr. or Ms. «ClaimantsLastName»:

We have received your request for a reconsideration of your application for Income Continuation Insurance (ICI) through the State of Wisconsin. We have carefully reviewed your application and are sorry to inform you that the original decision to deny your application was correct. You do have another opportunity to apply for coverage – you may submit another application after twelve (12) months from the date your original application was denied.

If you do not agree with this determination, you may request a Departmental Determination through the State of Wisconsin Department of Employee Trust Funds (DETF). A request for a Departmental Determination should be submitted, along with any additional information that you feel supports a reversal, to the following address:

Department of Employee Trust Funds (DETF)
ATTN: Eligibility, Inquiry and Resolution Section
P. O. Box 7931
Madison, WI 53707-7931

Please be aware that your request for a Department Determination must be received within ninety (90) days from the date of this letter.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Once again, we are sorry we could not meet your insurance needs at this time.

Sincerely,

Broadspire

cc: Department of Employee Trust Funds